STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPLI	ETED
		155245	A. BUII B. WIN			07/30/2	2012
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				86TH ST		
CASTLET	TON HEALTH CAR	E CENTER			APOLIS, IN 46256		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0000							
K0000	Licensure Survey Walk-thru Survey Indiana State Dej accordance with Survey Date: 07 Facility Number: Provider Number: AIM Number: 1 Surveyor: Mark Code Specialist At this Life Safet Health Care Cent compliance with Participation in M CFR Subpart 483 Fire and the 2000 Fire Protection A Life Safety Code Existing Health C 410 IAC 16.2. This one story fa be of Type V (11 sprinklered. The system with smo- corridors and in a	: 000149 r: 155245	K00	000	K0000 Element #1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; It is the policy of this facility to ensure a fire alarm system required for life safety is install tested and maintained. That each and every resident room have a working, tested and monitored smoked detector. Element #2 How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential be affected by this practice. Room 235 has a new smoke detector. The maintenance director or designee will monite all rooms for smoke detectors weekly.	led,	
					All residents have the potentia	l to	
	•	Caraher, Life Safety			tested and maintained . That		
	Code Specialist						
	code specialist				each and every resident room		
	At this Life Safet	ty Code survey, Castleton			_		
		-			monitorea smokea detector.		
					Floment #2		
	•	•			Element #2		
	Participation in N	Medicare/Medicaid, 42					
	•				How will you identify other		
	CFR Subpart 483	3.70(a), Life Safety from				al I	
	Fire and the 2000	edition of the National				41	
		. , , , , , , , , , , , , , , , , , , ,			deficient		
		. , , , , , , , , , , , , , , , , , , ,			delicient		
		. , , , , , , , , , , , , , , , , , , ,					
	Life Safety Code	(LSC) Chanter 19					
	Life Safety Code	(LSC), Chapter 19,					
					nunction and substantiations		
					practice and what corrective		
	Existing Health (Care Occupancies and			I = -		
	Existing Health (Care Occupancies and			I = -		
	Existing Health (Lare Occupancies and			I = -		
		care occupanions and			action will be taken:		
	410 IAC 16 2				action will be taken;		
	410 IAC 16.2.						
					All residents have the notantia	l to	
			1		All residents have the potentia	il to	
	This care of	.:1:2	1				
	This one story fa	cility was determined to	1		be affected by this practice.		
	•		1				
	he of Type V (11	1) construction and fully	1		Room 235 has a new smoke		
	oc of Type v (11	1) construction and fully	1				
	enrinklared The	facility has a fire alarm	1		detector. The maintenance		
	sprinkierea. The	racility has a life alarm	1		director or designee will monite	or I	
	gratam with are	lea datastian in the	1		_	٠ _'	
	system with smo	ke detection in the	1		all rooms for smoke detectors		
	agraidana and i	all aroug anon to the	1				
	corridors and in a	an areas open to the	1		weekiy.		
			1				
	commor. The fac	only has battery operated			1		
			1				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000149

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED
		155245	B. WIN	G		07/30/2012
NAME OF P	PROVIDER OR SUPPLIER	· }			ADDRESS, CITY, STATE, ZIP CODE	
CACTIE		C CENTED			86TH ST APOLIS, IN 46256	
	TON HEALTH CAR				APOLIS, IN 40200	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	``	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
		in all resident sleeping		1110	Element #3	Bills
		lity has a capacity of 109				
		s of 62 at the time of this			What measures will be put in	to
	visit.	of of of at the time of this			place or what systemic	
					changes you will make to ensure that the deficient	
	The facility was	found in compliance with			practice does not recur;	
	I -	regard to sprinkler				
	coverage and wa	• •			At an all staff in-service held o Tuesday August 14, 2012 the	n
	compliance with	the state law in regard to			need for smoke detectors in ea	ach
	smoke detector of	coverage.			and every resident room was	
					discussed.	
	All areas where	the residents have			Element #4	
	customary acces	s were sprinklered. The			Liomone #4	
	facility has one of	detached building			How the corrective actions w	/ill
	providing facility	y services such as a			be monitored to ensure the	
	laundry and a ma	aintenance shop which			deficient practice will not recur; ie what quality	
	were sprinklered	l.			assurance program will be p	ut
					into place; and completion	
		Lex Brashear, Life			date.	
	on 08/02/12.	alist-Medical Surveyor			At the monthly Quality Assurar	nce
	011 08/02/12.				meetings the results of the we	
	The facility was	found not in compliance			monitoring by the maintenance	e
	l	entioned regulatory			director or designee was discu	ISS.
		evidenced by the			Any negative patterns will be addressed. If necessary, an	
	following:				action plan will be written by a	
	<i>G</i> .				committee appointed by the	
					administrator. This plan will be monitored by the administrator	ı
					until all goals are met.	

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Event ID: 5ECN21

Facility ID: 000149

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	01	COMPL	ETED
		155245	B. WING	ING		07/30/	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			86TH ST		
CASTLE	TON HEALTH CAF	RE CENTER			APOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		REFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	NFPA 101	R LSC IDENTIFYING INFORMATION)		TAG	BEIGERGI		DATE
K0025 SS=E		CODE STANDARD					
33-E		are constructed to provide at					
		hour fire resistance rating in					
		n 8.3. Smoke barriers may					
	terminate at an	atrium wall. Windows are					
		e-rated glazing or by wired					
		d steel frames. A minimum of					
	•	ompartments are provided on					
		pers are not required in duct smoke barriers in fully ducted					
	•	ting, and air conditioning					
		3.7.3, 19.3.7.5, 19.1.6.3,					
	19.1.6.4	.5.7.5, 15.6.7.5, 15.1.5.5,					
	Based on observ	vation and interview, the	K002	5			08/16/2012
		ensure 2 of 2 openings			F025		
					1 023		
	_	ing into the attic above the			El		
		om was maintained to			Element #1		
	-	a one half hour fire					
	resistance rating	g. This deficient practice			What corrective		
	could affect any	resident, staff or visitor			action(s) will be		
	in the vicinity of	f the Mechanical Room by			• •		
	the Kitchen.				accomplished for		
	Finding sign 1 4				those residents	_	
	Findings include	e:			found to have beer	1	
	Based on observ	vations with the			affected by the		
		rector during a tour of the			deficient practice;		
		-			It is the policy of this facility to	0	
	<u> </u>	:45 a.m. to 12:55 p.m. on			ensure that smoke barriers		
		was a two foot diameter			provide a one half hour fire		
		nch by six inch opening in			resistance rating in accordanc	е	
	•	e Mechanical Room by			with 8.3. Smoke barriers.		
	the Kitchen whi	ch were not firestopped.			Element #2		
	Based on intervi	iew at the time of					
	observation, the	Maintenance Director			How will you identi	ify	
	,	eak damaged the ceiling			other residents	-	
					other residents		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED
		155245	B. WING		07/30/2012
	PROVIDER OR SUPPLIEF		7630	T ADDRESS, CITY, STATE, ZIP CODE E 86TH ST NAPOLIS, IN 46256	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	REGULATORY OR causing the two ceiling and ackn aforementioned	foot diameter hole in the owledged the openings in the ceiling of Room by the Kitchen		CROSS-REFERENCED TO THE APPROPRIA	DATE DATE AI P P P P P P P P P P P P P
				How the corrective	,

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Event ID: 5ECN21

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T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155245	A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 07/30/2012
		7630 E	86TH ST	
(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
REGULATOR I OF	CLOC IDENTIFICATION INFORMATION)		actions will be monitored to enset the deficient practice will not recur; ie what quality assurance program will be put into place; an completion At the monthly quality assurance was reviewed any reports of negative results the Administ shall appoint a review team monitor and report until resorts.	ure d urance ches f strator to
	OF CORRECTION ROVIDER OR SUPPLIE ON HEALTH CAF SUMMARY S (EACH DEFICIEN	OF CORRECTION IDENTIFICATION NUMBER:	OF CORRECTION IDENTIFICATION NUMBER: 155245 ROVIDER OR SUPPLIER TON HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL A. BUILDING B. WING STREET 7630 E INDIAN PREFIX	ROVIDER OR SUPPLIER ROVIDER O

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Event ID: 5ECN21

Facility ID: 000149

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AND PLAN	T OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIE	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155245	A. BUILDING B. WING STR	EET ADDRESS, CITY, STATE, ZIP CODE	X3) DATE SURVEY COMPLETED 07/30/2012
CASTLE	TON HEALTH CAF	RE CENTER		30 E 86TH ST DIANAPOLIS, IN 46256	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO THE APPROPR	
K0029 SS=E	One hour fire rafire-rated doors fire extinguishin 8.4.1 and/or 19 areas. When the extinguishing sy areas are separ smoke resisting are self-closing protective plates inches from the permitted. 19 Based on observate facility failed to receptacles in the were stored in a fire resistance rapractice could a visitor in the vice. Findings include Based on observation of the permitted of the vice of the permitted of the permitted of the permitted. The permitted of th		K0029	K 029 Element #1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; It is the policy of the facility to ensure that 32 gallow mobile soiled linen or trash collection receptacles are at distance of not less than 64 square foot area of each other. The 32 mobile soiled linen or trash collection receptacles are at distance of not less than 64 square foot area of each other. The 32 mobile soiled linen or trash collection receptacles are at distance than 64 so feet of each other at this time. Element #2 How will you identify other residents have the potential to be affected the same deficient practice what corrective action will taken; All residents have the potential to be affected by this practice. The maintenance director or designee will mon that the 32 gallon mobile soil linen and trash collection receptacles are not less than square feet from each other.	nis on a er. are at quare b. cing by and be es s itor ed 64

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	OF CORRECTION IDENTIFICATION NUMBER: 155245	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPLETED 07/30/2012
	PROVIDER OR SUPPLIER ETON HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PERCEDED BY FULL	STREET A 7630 E	ADDRESS, CITY, STATE, ZIP CODE 86TH ST APOLIS, IN 46256 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	BE COMPLETION
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) providing a one hour fire fire resistance rating. 3.1-19(b)	PREFIX TAG	weekly checking will be (3) weekly on-going and will be part of the preventive maintenance done by the maintenance department. (4) weeks of 100% complia this monitoring will be once weekly. Any negative finding be corrected as found. Ele #3 What measures will be into place or what system changes you will make to ensure that the deficient practice does not recur; all staff in-service held on Tuesday August 14, 2012 need to keep the 32 gallon soiled linen and trash collect receptacles at a greater disthan 64 square feet (8)ft by was discussed. Any staff was to comply will be progressive discipline as appropriate. Element #4 How the correct actions will be monitored ensure the deficient practive will not recur; ie what quality assurance program will be into place; and completion date. At the monthly Quality Assurance meetings the rest of the monitoring by the maintenance director or deady negative patterns will be addressed. If necessary, a action plan will be written by committee appointed by the administrator. This plan will monitored by the administrator. This plan will monitored by the administrator. This plan will monitored by the administrator. It is plan will monitored by the administrator. This plan will monitored by the administrator. This plan will monitored by the administrator. This plan will monitored by the administrator.	After nce Agree and a second a

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Facility ID: 000149

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED	ED
r. Dollading	
155245 O7/30/2012	12
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER 7630 E 86TH ST	
CASTLETON HEALTH CARE CENTER INDIANAPOLIS, IN 46256	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
CROSS-REFERENCED TO THE APPROPRIATE	OMPLETION
'	DATE
K0038 NFPA 101 SS=E LIFE SAFETY CODE STANDARD	
SS=E LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are	
readily accessible at all times in accordance	
with section 7.1. 19.2.1	
Based on observation and interview, the K0038	8/16/2012
facility failed to ensure the means of	
egress through 2 of 7 exits were readily	
accessible for residents without a clinical	
diagnosis requiring specialized security Element #1	
measures. LSC 19.2.2.2.4 requires doors	
within a required means of egress shall What corrective action(s) will be accomplished for these	
not be equipped with a latch or lock that be accomplished for those residents found to have been	
requires the use of a tool or key from the affected by the deficient	
egress side. Exception No. 1 requires practice;	
door locking arrangements without	
deleved corose shall be permitted in health	
that starr, visitors cto readily	
care occupancies, or portions of health care occupancies, where the clinical needs care occupancies where the clinical needs care occupancies where the clinical needs	
neeted at each key and evit	
of the residents require specialized	
security measures for their safety, Element #2	
provided staff can readily unlock such	
doors at all times. This deficient practice How will you identify other	
affects any resident, staff or visitor residents having the potential	
needing to exit the facility by Room 134 to be affected by the same deficient practice and what	
and by Room 201. corrective action will be taken;	
Findings include: All person who enter the facility	
have the potential to be affected	
Based on observations with the by this practice.	
Maintenance Director during a tour of the All exits which have key pads now	
facility from 10:45 a.m. to 12:55 p.m. on have the code posted above the	
07/30/12, seven exit doors were	
magnetically locked and could be opened	
by entering a four digit code but the code The maintenance director or his/her designee will monitor	

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	OF CORRECTION OF CORRECTION 155245	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 07/30/2012
	PROVIDER OR SUPPLIER TON HEALTH CARE CENTER	7630 E	ADDRESS, CITY, STATE, ZIP CODE 86TH ST APOLIS, IN 46256	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	was not posted at the exit door by Room 134 and by Room 201. Based on interview with the Maintenance Director at the time of the observations, the residents who have a clinical diagnosis to be in a secure building are housed in the secure memory care area and not near the aforementioned facility exits. The Maintenance Director went on to say, a resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the exit access code. Based on interview at the time of the observations, the Maintenance Director acknowledged the four digit exit code was not posted at the facility exit by Room 134 and by Room 201. 3.1-19(b)		monthly all exits with key pads ensure codes are posted. This monthly checking will be on-going. Any negative findin will be corrected immediately. Element #3 What measures will be put into place or what systemic change you will make to ensure that the deficient practice does not reconstructed. At an all staff in-service held on Tuesday August 14, 2012, the need to have codes posted aball key pad exits was discussed. Element #4 How the corrective actions was be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completic date. At the monthly Quality Assurant meetings the results of the rounds made by the administrator designee was reviewed. An patterns will be addressed. If necessary, an action plan will written by a committee appoin by the administrator. This plan be monitored weekly by the administrator until all goals are met.	gs Description D

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		IDENTIFICATION NUMBER: 155245	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPI 07/30	LETED
NAME OF P	ROVIDER OR SUPPLIER			address, city, state, zip co 86TH ST	DDE	-
CASTLETON HEALTH CARE CENTER				APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DINC	01	COMPL	ETED
		155245	A. BUII B. WIN	A. BUILDING 07/30		07/30/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				86TH ST		
CASTLE	TON HEALTH CAR	E CENTER			APOLIS, IN 46256		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0050 SS=C	NFPA 101 LIFE SAFETY C Fire drills are hel varying condition shift. The staff is and is aware tha routine. Respon conducting drills competent perso exercise leaders conducted between announcement in audible alarms. Based on record facility failed to drills at unexpect conditions on 1 or quarters. This deall occupants in the Findings include Based on a review documentation with Director during rails and the drills conducted and the drills co	ODE STANDARD Id at unexpected times under its, at least quarterly on each is familiar with procedures to drills are part of established sibility for planning and its assigned only to ons who are qualified to hip. Where drills are seen 9 PM and 6 AM a coded may be used instead of 19.7.1.2 review and interview, the conduct quarterly fire sted times under varying of 3 shifts for 3 of 4 efficient practice affects the facility. : w of "Fire Drill Report" with the Maintenance record review from 9:15 in. on 07/30/12, third shift eted on 11/16/11, 11/12 were conducted, 1:55 a.m., 4:40 a.m. and on interview at the time, the Maintenance ledged third shift fire onducted at unexpected	K00		K50 Element #1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; It is the policy of this facility to ensure that quarterly fire drills each shift for all (4) quarters annually. Element #2 How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take All residents have the potential be affected by this practice. To maintenance director or designation.	on lito he	DATE 08/16/2012
	3.1-19(b)				will monitor all fire drills month to ensure they are being		

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED	
		155245	B. WIN	G		07/30/2012	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					86TH ST		
CASTLE	TON HEALTH CAR	E CENTER		INDIAN	APOLIS, IN 46256		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		ION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG		DATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	conducted regularly and at different times and days throughout the week or time period per NFPA 101 Life Safe Standard. This monthly check all fire drills will be given to the administrator or designee at the last day of each month. This weekly checking will be on-going. Any negative finding will be corrected immediately. Element #3 What measures will be put implace or what systemic changes you will make to ensure that the deficient practice does not recur; At an all staff in-service held on Tuesday February 03, 2009 the need to have fire drills on each shift for 1 of 4 quarters and at unexpected times was discussed. Element #4 How the corrective actions we be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be possible.	ety of see gs to	
					into place; and completion date.		
					uale.		
					At the monthly Quality Assurant meetings the results of the monthly monitoring by the maintenance director or design		

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	OF CORRECTION	IDENTIFICATION NUMBER: 155245	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPI 07/30		
	PROVIDER OR SUPPLIE	RE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)		(X5) COMPLETION DATE	
TAG	REGULATORY OF	RESC IDENTIFYING INFORMATION)	TAG	and the administrator or of was discuss. Any negative patterns will be addressed necessary, an action plan written by a committee apply the administrator. This be monitored by the admit until all goals are met.	lesignee e d. If will be pointed plan will	DATE	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155245 NAME OF PROVIDER OR SUPPLIER CASTLETON HEALTH CARE CENTER		(X2) MU A. BUIL B. WING	DING STREET A 7630 E	ONSTRUCTION 01 ADDRESS, CITY, STATE, ZIP CODE 86TH ST APOLIS, IN 46256	(X3) DATE S COMPL 07/30/	ETED	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
K0052 SS=F	A fire alarm systic installed, tested, accordance with Code and NFPA approved mainter complying with a NFPA 70 and 72 Based on observing facility failed to detectors in acconstruction of the construction of the complete of	ation and interview, the maintain 2 of 36 smoke rdance with NFPA 72. 1 requires in spaces adding systems, smoke of the located where operation of the A 72, A-2-3.5.1 explains should not be located in nor closer than 3 feet by diffuser or return air efficient practice could staff or visitors in the cinity of the Custom e wall cross corridor door sinity of the Marshall is corridor door set.	K00	52	K052 Element #1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; It it's the policy of this facility to ensure that a fire alarm system require for life safety is maintained in accordance with NFPA 70 National Electrical C and NFPA 72. Custom Boulev ceiling fans by the smoke wall cross corridor door set and in corridor next to the Marshall smoke wall cross corridor door set blades have been remove and will never be put back. Element #2 How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take. All resident have the potential	ode vard the	08/16/2012

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NAME OF PROVIDER OR SUPPLIER CASTLETON HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) The corridor next to the Marshall smoke wall cross corridor door set were each located in the ceiling within one foot of a ceiling fan. Based on interview at the STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256 ID PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DEFICIENCY DATE OTHER ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE TAG DEFICIENCY DATE DEFICIENCY DATE OTHER APPROPRIATE DEFICIENCY DATE The maintenance director or designee will monitor all hard wired smoke detectors monthly to ensure no interference has been	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155245			(X2) MULTIPLE (A. BUILDING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/30/2012
Total Each of Provider or Supplier CASTLETON HEALTH CARE CENTER Total Summary statement of Deficiencies PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG TAG The corridor next to the Marshall smoke wall cross corridor door set were each located in the ceiling within one foot of a Total Castle State Total Providers Plan of Correction (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG Total E 86TH ST INDIANAPOLIS, IN 46256 (X5) COMPLETION DATE Total Providers Plan of Correction (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Total Providers Plan of Correction (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Total Providers Plan of Correction (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Total Providers Plan of Correction (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Total Providers Plan of Correction (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Total Providers Plan of Correction (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Total Providers Plan of Correction (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Total Providers Plan of Correction (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Total Providers Plan of Correction (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Total Providers Plan of Correction (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Total Providers Plan of Correction (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Total Providers Plan of Correction (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Total Providers Plan of Correction (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Total Provi			155245		CADDREGG CITY GTATE TIL CODE	07/30/2012
CASTLETON HEALTH CARE CENTER INDIANAPOLIS, IN 46256 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) the corridor next to the Marshall smoke wall cross corridor door set were each located in the ceiling within one foot of a ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DEFICIENCY Deagle Providers PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE DEFICIENCY TAG DEFICIENCY DATE TO MICRO PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE DEFICIENCY TAG DEFICIENCY DATE DEFICIENCY DATE	NAME OF PRO	OVIDER OR SUPPLIER				
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH DEFICIENCY) PREFIX (EACH CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE COMPLETION DATE be affected by this practice. The maintenance director or designee will monitor all hard wired smoke detectors monthly to ensure no	CASTLETC	ON HEALTH CAR	E CENTER			
wall cross corridor door set were each located in the ceiling within one foot of a maintenance director or designee will monitor all hard wired smoke detectors monthly to ensure no	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
time of the observations, the Maintenance Director acknowledged the two smoke detectors were each installed within one foot of a ceiling fan at the aforementioned locations. 3.1-19(b) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; At an in-service held August 14, 2012 the ceiling fans and there interference was discussed. Element #4 How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date. At the monthly Quality Assurance meetings the results of the monthly monitoring by the maintenance director or designee was discuss. Any negative patterns will be addressed. If necessary, an action plan will be written by a committee appointed by the administrator. This plan will be monitored by the administrator until all goals are met.	t v l l c c t l l l l l l l l l l l l l l l	the corridor next wall cross corrid located in the cer ceiling fan. Base time of the obser Director acknow detectors were ea foot of a ceiling locations.	to the Marshall smoke or door set were each cling within one foot of a ed on interview at the evations, the Maintenance ledged the two smoke ach installed within one		maintenance director or desig will monitor all hard wired smodetectors monthly to ensure n interference has been established. Element #3 What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur; At an in-service held August 1 2012 the ceiling fans and then interference was discussed. Element #4 How the corrective actions who be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completed date. At the monthly Quality Assurant meetings the results of the monthly monitoring by the maintenance director or desig was discuss. Any negative patterns will be addressed. If necessary, an action plan will written by a committee appoin by the administrator. This plan be monitored by the administrator.	The nee oke o

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155245 NAME OF PROVIDER OR SUPPLIER CASTLETON HEALTH CARE CENTER INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K0064 NFPA 101 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256 (X5) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETED 07/30/2012 STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256 (X5) PREFIX (EACH OF RECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K0064 NFPA 101	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE S				
NAME OF PROVIDER OR SUPPLIER CASTLETON HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K0064 NFPA 101 STREET ADDRESS, CITY, STATE, ZIP CODE (7630 E 86TH ST INDIANAPOLIS, IN 46256 (X5) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE	AND PLAN OF COR	RRECTION		A. BUI	LDING	01		
NAME OF PROVIDER OR SUPPLIER CASTLETON HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K0064 NFPA 101 TAG 1630 E 86TH ST INDIANAPOLIS, IN 46256 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE			155245	B. WIN			07/30/2	.'U12
CASTLETON HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	NAME OF PROVID	ER OR SUPPLIER						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K0064 NFPA 101 (X5) COMPLETION DEFICIENCY) DATE								
PREFIX TAG	CASTLETON	HEALTH CAR	E CENTER		INDIAN	IAPOLIS, IN 46256		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K0064 NFPA 101 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE								* 1
K0064 NFPA 101	,	•				CROSS-REFERENCED TO THE APPROPRIA	ATE	
			LSC IDENTIFYING INFORMATION)		IAG	DEFICIENCY)	+	DATE
SS=E LIFE SAFETY CODE STANDARD			ODE STANDARD					
Portable fire extinguishers are provided in all								
health care occupancies in accordance with								
9.7.4.1. 19.3.5.6, NFPA 10	9.7	'.4.1. 19.3.5	.6, NFPA 10					
		Based on observation and interview, the facility failed to inspect 1 of 11 portable		K00)64	1,, 22,4		08/16/2012
						n 064		
fire extinguishers in the facility each Element #1		•	•			Element #1		
month. NFPA 10, Standard for Portable								
Fire Extinguishers, Section 4-3.4.2 What corrective action(s) will	Fire	Fire Extinguishers, Section 4-3.4.2					11	
requires fire extinguisher inspections at be accomplished for those	requires fire extinguisher inspections at				•	_		
least monthly with the date of inspection residents found to have been affected by the deficient	leas	t monthly wit	th the date of inspection				n	
and the initials of the person performing practice;	and	the initials of	f the person performing			_		
being recorded. In addition, NFPA 10,	bein	g recorded.	In addition, NFPA 10,			,		
Section 4-2.1 defines inspection as a lt is the policy of this facility to	Sect	tion 4-2.1 def	ines inspection as a					
"quick check" to ensure the fire ensure that fire extinguishers are inspected monthly for working	"qui	ick check" to	ensure the fire					
extinguisher is available and will operate.	exti	nguisher is av	vailable and will operate.				'	
It is intended to give reasonable assurance	It is	intended to g	give reasonable assurance					
the fire extinguisher is fully charged and Element #2	the f	fire extinguis	her is fully charged and			Element #2		
operable, verifying that it is in its	oper	rable, verifyii	ng that it is in its					
designated place, it has not been actuated How will you identify other residents having the potential	desi	gnated place,	it has not been actuated				al	
or tampered with and there is no obvious to be affected by the same	or ta	ampered with	and there is no obvious				ai	
or physical damage or condition to deficient practice and what	or p	hysical dama	ge or condition to			_		
prevent its operation. This deficient corrective action will be taken;	prev	ent its operat	tion. This deficient			corrective action will be take	∍n;	
practice could affect any staff or visitor in	prac	tice could af	fect any staff or visitor in			All manidants have the rest of	-14-	
the vicinity of the Laundry Room. All residents have the potential to be affected by this practice. The	the	vicinity of the	e Laundry Room.					
maintenance director or designee						•		
Findings include: will monitor the fire extinguishers	Finc	dings include	:			will monitor the fire extinguish	ers	
monthly to ensure this practice is		-					e is	
Based on observation with the being completed.	Base	ed on observa	ation with the			being completed.		
Maintenance Director during a tour of the	Mai	ntenance Dir	ector during a tour of the					
facility from 10:45 a.m. to 12:55 p.m. on Element #3			C			Element #3		
07/30/12, the annual maintenance tag What measures will be put into		-	•			-	nto	
attached to the portable fire, extinguisher place or what systemic			· ·			, · · · · · · · · · · · · · · · · · · ·		
located in the soiled side of the Laundry changes you will make to		-	_			changes you will make to		

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	OF CORRECTION	IDENTIFICATION NUMBER: 155245	A. BUILDING B. WING	01	COMPLETED 07/30/2012
	PROVIDER OR SUPPLIER		STREET 7630 E	ADDRESS, CITY, STATE, ZIP CODE 86TH ST NAPOLIS, IN 46256	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
	Room indicated inspection for the extinguisher was	·		ensure that the deficient practice does not recur; At an all staff in-service held	Lon
	observation, the	interview at the time of Maintenance Director aware a fire extinguisher		Tuesday August 14, 2012 the need to monitor fire extinguismonthly was discussed.	ne
	Laundry Room a	e soiled side of the and acknowledged the thly inspection for this		Element #4 How the corrective actions	will
	portable extingui January 2012.	isher was performed		be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be	
	3.1-19(b)			into place; and completion date.	
				At the monthly Quality Assumeetings the results of the monitoring by the maintenar director or designee was discussed. Any negative pat will be addressed. If necess an action plan will be written committee appointed by the administrator. This plan will monitored by the administratuntil all goals are met.	nce eterns eary, n by a

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	01	COMPL	ETED
		155245	B. WIN			07/30/2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				86TH ST		
CASTLE	TON HEALTH CAR	E CENTER			APOLIS, IN 46256		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0075 SS=E	Soiled linen or trans to exceed 32 gas average density room or space decreased with a context of the soil receptacles with gal (121 L) are less a hazardous area 19.7.5.5	ODE STANDARD ash collection receptacles do al (121 L) in capacity. The of container capacity in a oes not exceed .5 gal/sq ft a capacity of 32 gal (121 L) is thin any 64 sq ft (5.9-sq m) led linen or trash collection capacities greater than 32 ocated in a room protected as a when not attended.	Voc	N7.5			09/17/2013
	Based on observa	ation and interview, the	K00)75			08/16/2012
	facility failed to	ensure a capacity of 32			K 075		
	gallons for mobil	le soiled linen or trash acles was not exceeded			Element #1		
	within any 64 sq corridors. This c	uare feet area for 1 of 7 deficient practice could nt, staff or visitor in the			What corrective action(s) wil be accomplished for those residents found to have beer affected by the deficient practice;		
	facility from 10:4 07/30/12, two 32 soiled linen recepsoiled linen and stored next to each by Room 107. Be time of observation Director acknowlinen receptacles				It is the policy of this facility to ensure that 32 gallon mobile soiled linen or trash collection receptacles are at a distance on the less than 64 square foot at of each other. The 32 mobile soiled linen or trash collection receptacles are at a greater distance than 64 square feet of each other at this time. Element #2 How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take	rea f	

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	of deficiencies (X1) provider/supplier/clia (IDENTIFICATION NUMBER: 155245	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 07/30/2012		
	OVIDER OR SUPPLIER ON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	square feet corridor area near Room 107. 3.1-19(b)		All residents have the potential be affected by this practice. To maintenance director or design will monitor that the 32 gallon mobile soiled linen and trash collection receptacles are not than 64 square feet from each other. This weekly checking be (3) times weekly on-going will become part of the previous maintenance done by the maintenance department. Aft. (4) weeks of 100% compliance this monitoring will be once weekly. Any negative findin will be corrected as found. Element #3 What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur; At an all staff in-service held of Tuesday August 14, 2012 the need to keep the 32 gallon mosoiled linen and trash collection receptacles at a greater distant than 64 square feet (8)ft by (8 was discussed. Any staff who to comply will be progressively discipline as appropriate. Element #4 How the corrective actions we be monitored to ensure the deficient practice will not recur; ie what quality	The nee less g will and us er e gs on cobile on nce) fail		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155245	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 07/30/2012		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	•		
CASTLET	ΓΟΝ HEALTH CAR	E CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DBE COMPLETION DATE		
				assurance program will b into place; and completio date.	- I		
				At the monthly Quality Ass meetings the results of the monitoring by the maintena director or designee Any repatterns will be addressed necessary, an action plan written by a committee app by the administrator. This pe monitored by the admin until all goals are met.	ance egative If will be sointed blan will		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155245	A. BUII		01	07/30/	
		100240	B. WIN		ADDRESS CITY STATE ZID CODE	017307	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE 86TH ST		
CASTLE	TON HEALTH CAR	E CENTER			APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re	COMPLETION
TAG K0143	NFPA 101	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCI)		DATE
SS=E	LIFE SAFETY C Transferring of o						
	wherein patients	m any portion of a facility are housed, examined, or aration of a fire barrier of ive construction;					
		at is mechanically ventilated, has ceramic or concrete					
	transferring is oc the immediate ar accordance with	sted with signs indicating that curring, and that smoking in rea is not permitted in NFPA 99 and the s Association. 8.6.2.5.2					
	Based on observa	ation and interview, the	K01	43			08/16/2012
	facility failed to	ensure 1 of 1 liquid			K 143	ļ	
		reas where oxygen s place, was enclosed by			Element #1		
	_	stive enclosure. NFPA			What corrective action(s) will	I	
	80, the Standard	for fire Doors and Fire			be accomplished for those	ļ	
	Windows at 2-4.	1.4 requires all closing			residents found to have been affected by the deficient		
	mechanisms shal	l be adjusted to			practice;		
	overcome the res	sistance of the latch			,		
	mechanism so po	sitive latching is			It is the policy of this facility to		
	achieved on each	door operation. This			all doors serving hazardous ar such as the oxygen storage ro		
	deficient practice	e could affect residents,			close and latch to prevent the	OIII	
	staff and visitors	in the vicinity of the ICF			passage of smoke.		
	area storage roor	n.			The evagen eterage reem	out.	
	Findings include	:			The oxygen storage room with the proper closure and latch habeen repaired.		
	Based on observa	ation with the			Element #2	ļ	
	Maintenance Dir	ector during a tour of the			How will you identify other		

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NAME OF PROVIDER OR SUPPLIER CASTLETON HEALTH CARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) facility from 10:45 a.m. to 12:55 p.m. on 07/30/12, the oxygen storage and transfilling room latching hardware was not secured into the door which caused the door to not latch into the door frame. Based on interview at the time of observation, the Maintenance Director acknowledged the oxygen storage and transfilling room entry door latching hardware was not secured which caused the entry door to not latch into the door frame. 3.1-19(b) BYTREET ADDRESS, CITY, STATE, ZIP CODE TROOD BATH STINDIANAPOLIS, IN 46256 ID PREFIX TAG DEPONDENT ACTION SIROLINE COMPLETION DATE TAG TROOD BATH STINDIANAPOLIS, IN 46256 ID PREFIX TAG DEPONDENT ACTION SIROLINE COMPLETION DATE TAG TROOD BATH STINDIANAPOLIS, IN 46256 CASTLETON HEALTH CARE CENTER INDIANAPOLIS, IN 46256 ID PREFIX TAG DEPONDENT ACTION SIROLINE COMPLETION DATE TAG TROOD BATH STINDIANAPOLIS, IN 46256 TAG DEPONDENT ACTION SIROLINE COMPLETION DATE TAG TROOD BATH STINDIANAPOLIS, IN 46256 TAG DEPONDENT ACTION SIROLINE COMPLETION DATE TAG TROOD BATH STINDIANAPOLIS, IN 46256 TAG DEPONDENT ACTION SIROLINE COMPLETION DATE TAG TROOD BATH STINDIANAPOLIS, IN 46256 TAG DEPONDENT ACTION SIROLINE COMPLETION DATE TAG TROOD BATH STINDIANAPOLIS, IN 46256 TAG DEPONDENT ACTION SIROLINE COMPLETION DATE TAG TROOD BATH STINDIANAPOLIS, IN 46256 TAG DEPONDENT ACTION SIROLINE COMPLETION DATE TAG TROOD BATH STINDIANAPOLIS, IN 46256 TAG DEPONDENT ACTION SIROLINE COMPLETION DATE TAG TROOD BATH STINDIANAPOLIS, IN 46256 TAG DEPONDENT ACTION SIROLINE COMPLETION DATE TAG DEPONDENT ACTION SIROLI	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
NAME OF PROVIDER OR SUPPLIER CASTLETON HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) facility from 10:45 a.m. to 12:55 p.m. on 07/30/12, the oxygen storage and transfilling room is connected to the ICF area storage room. The entry door to the oxygen storage and transfilling room latching hardware was not secured into the door which caused the door to not latch into the door frame. Based on interview at the time of observation, the Maintenance Director acknowledged the oxygen storage and transfilling room entry door latching hardware was not secured which caused the entry door to not latch into the door frame. 3.1-19(b) STRIET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256 ID PROVIDERS TRANSIC COMPRECTION (CS) (X5) (X5) (X5) (PREFIX TAG TO THE APPROPRIATE DEPROPRIATE DEPROPRIATE TO THE APPROPRIATE DEPROPRIATE DEPROPR	AND PLAN	OF CORRECTION		A. BUILDING	01	
CASTLETON HEALTH CARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) facility from 10:45 a.m. to 12:55 p.m. on 07/30/12, the oxygen storage and transfilling room is connected to the ICF area storage room. The entry door to the oxygen storage and transfilling room latching hardware was not secured into the door which caused the door to not latch into the door frame. Based on interview at the time of observation, the Maintenance Director acknowledged the oxygen storage and transfilling room entry door latching hardware was not secured which caused the entry door to not latch into the door frame. 3.1-19(b) Tag Devices as As of Correction (X5) PREFIX TAG PROVIDER AS AS OF CORRECTION (CMPLETION DATE Tag PREFIX TAG PROVIDER AS OF COMPLETION (CMPLETION DATE) PREFIX TAG PROVIDER AS OF CORRECTION (CMPLETION DATE) PROVIDER AS OF COR			155245			07/30/2012
Maintenance Director acknowledged the oxygen storage and transfilling room entry door latching hardware was not secured which caused the entry door to not latch into the door frame. 3.1-19(b) All doors serving hazardous areas for proper closing and latching. This monthly checking will be on-going and will become part of the preventive maintenance done by the maintenance department. Any negative findings will be	NAME OF CASTLE (X4) ID PREFIX	PROVIDER OR SUPPLIED SUMMARY S (EACH DEFICIEN REGULATORY OF facility from 10: 07/30/12, the ox transfilling room area storage room oxygen storage a latching hardwat the door which of latch into the do	RE CENTER STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL RESC IDENTIFYING INFORMATION) 45 a.m. to 12:55 p.m. on ygen storage and in is connected to the ICF m. The entry door to the and transfilling room are was not secured into caused the door to not or frame. Based on	STREET A 7630 E INDIAN ID PREFIX	ADDRESS, CITY, STATE, ZIP CODE 86TH ST IAPOLIS, IN 46256 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) residents having the potentiato be affected by the same deficient practice and what corrective action will be taked. All residents have the potential be affected by this practice. A facility wide audit was conduct to ensure all doors serving hazardous areas have the pro	COMPLETED 07/30/2012 (X5) COMPLETION DATE al in; I to ed per
Element #3 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; At an all staff in-service held on Tuesday August 14, 2012 the need to ensure all doors serving hazardous areas and proper closing and latching procedures		interview at the Maintenance Disorvegen storage a entry door latchi secured which control latch into the	time of observation, the rector acknowledged the and transfilling rooming hardware was not aused the entry door to		closure apparatus and latching hardware required to allow proclosure. The maintenance director or designee will do a monthly aud of all doors serving hazardous ar for proper closing and latching. This monthly checking will be on-going and will become part the preventive maintenance do by the maintenance departme. Any negative findings will be corrected as found. Element #3 What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur; At an all staff in-service held of Tuesday August 14, 2012 the need to ensure all doors serving hazardous areas and proper	g pper dit dit eas dit dit eas

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155245		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/30/2012			
		100240	B. WING		0773072012		
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE			
			7630 E 86TH ST				
CASTLET	TON HEALTH CAR	E CENTER	INDIAN	IAPOLIS, IN 46256			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DATE		
				maintenance request is			
				completed was emphasized.	. to		
				Maintenance monthly rounds check hazardous areas door			
				and proper closing and latch			
				was also discussed. Any sta			
				who fail to comply with the po	oints		
				of the in-service will be further			
				educated and/or progressive	ly		
				disciplined as appropriate.			
				Element #4			
				How the corrective actions	will		
				be monitored to ensure the			
				deficient practice will not			
				recur; ie what quality	4		
				assurance program will be into place; and completion	put		
				date.			
				At the monthly Quality Assur	ance		
				meetings the results of the			
				rounds made by the Mainten			
				Supervisor or their designee	l l		
				be reviewed. Any patterns waterns waterns addressed. If necessary, an			
				action plan will be written by			
				committee appointed by the			
				administrator. This plan will b	oe		
				monitored weekly by the			
				administrator until all goals a	re		
				met.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE S	SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155245	1	WING		07/30/2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				86TH ST		
CASTLET	TON HEALTH CAR	E CENTER			APOLIS, IN 46256		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K9999							
	State Findings		K99	99			08/16/2012
	3.1-19 ENVIRO	NMENT AND					
	PHYSICAL STA				K 9999		
	THI SICIL SI				Element #1		
	3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following: (1) Have an automatic sprinkler system installed throughout the facility before				Element #1		
					What corrective action(s) wil	1	
					be accomplished for those	-	
					residents found to have beer	า	
					affected by the deficient		
	July 1, 2012.				practice;		
	(2) If an automat	ic sprinkler system is not					
		out the health care			It is the policy of this facility to		
		ly 1, 2010, submit before			ensure a fire alarm system required for life safety is install	lod	
	_				tested and maintained. That	ieu,	
		an to the department for			each and every resident room		
	completing the in				have a working, tested and		
	•	ler system before July 1,			monitored smoked detector.		
	2012.						
	(3) Have a batter	y operated or hard-wired			Element #2		
	smoke detector is	n each resident's room					
	before July 1, 20	12.			How will you identify other		
	,				residents having the potentia	11	
	This State Rule b	nas not been met as			to be affected by the same deficient		
	evidenced by:	not occurrent as			General		
		ation and internity the			practice and what corrective		
		ation and interview, the			action will be taken;		
	_	install smoke detectors in			,		
		rooms before July 1,			All residents have the potentia	l to	
	2012. This defic	ient practice could affect			be affected by this practice.		
	2 residents in the	facility.			Room 235 has a new smoke		
					detector. The maintenance	o.r	
	Findings include				director or designee will monitorall rooms for smoke detectors	UI .	
		-			weekly.		
	Based on observa	ation with the					
	Dased on observa	anon with the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUIL 155245 B. WING	07/30/201	O
NAME OF PROVIDER OR SUPPLIER CASTLETON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CO	(X5) MPLETION DATE
Maintenance Director during a tour of the facility from 10:45 a.m. to 12:55 p.m. on 07/30/12, a smoke detector was not installed in resident sleeping room #235. Based on interview at the time of observation, the Maintenance Director acknowledged a smoke detector was not installed in resident sleeping room #235. 3.1-19(ff)	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; At an all staff in-service held on Tuesday August 14, 2012 the need for smoke detectors in each and every resident room was discussed. Element #4 How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date. At the monthly Quality Assurance meetings the results of the weekly monitoring by the maintenance director or designee was discuss. Any negative patterns will be addressed. If necessary, an action plan will be written by a committee appointed by the administrator. This plan will be monitored by the administrator until all goals are met.	

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